IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA
CIVIL DIVISION

DAVID HINES, an individual,

Plaintiff,

vs.

MUTUAL OF OMAHA INSURANCE COMPANY and JOHN HUNTER, an individual,

Defendants.

No. GD 14-23509

Code 001

Issue No.

COMPLAINT

Filed on behalf of:
David Hines
Plaintiff

Counsel of Record for this Party:
Thomas Shannon Barry

Pa. I.D. # 50388

1103 East Carson Street
Pittsburgh, PA 15203

412-664-7414

IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA

DAVID HINES, an individual,	)	CIVIL DIVISION
	)	
Plaintiff,	)	No. GD 14-23509
	)	
vs.	)	
	)	
MUTUAL OF OMAHA INSURANCE COMPANY and JOHN HUNTER, an individual,	)	
	)	
Defendants.	)	

NOTICE TO DEFEND

You have been sued in Court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this Complaint and Notice are served, by entering a written appearance personally or by attorney and filing in writing with the Court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so, the case may proceed without you and a judgment may be entered against you by the Court without further notice for any money claimed in the Complaint or for any relief requested by the Plaintiff. You may lose money or property or other rights important to you.

You should take this paper to your lawyer at once. If you do not have or know a lawyer, then you should go to or telephone the office set forth below to find out where you can get legal help:

Lawyer Referral Service
The Allegheny County Bar Association
920 City County Building
Pittsburgh, PA 15219
Telephone: 412-261-0518

IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA

DAVID HINES, an individual, Plaintiff, vs. MUTUAL OF OMAHA INSURANCE COMPANY and JOHN HUNTER, an individual, Defendants.	)	CIVIL DIVISION No. GD 14-23509

COMPLAINT

AND NOW comes the Plaintiff, David Hines, by and through his attorney, Thomas Shannon Barry, Esquire, and files this Complaint in Civil Action based on the following:

1. The Plaintiff is David Hines, an adult individual, currently residing at 625 Maple Street, West Mifflin, Allegheny County, Commonwealth of Pennsylvania, 15122.

2. Defendant is Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska, 68175.

3. Defendant is John Hunter, 100 North Point Circle, Suite 206, Seven Fields, Allegheny County, Pennsylvania, 16046.

4. On September 7, 2013, Plaintiff set up an appointment with Defendant Hunter to fill out an application for disability payments with Defendant Mutual of Omaha.

5. At said meeting, Defendant Hunter posed questions to Plaintiff.

6. Plaintiff answered honestly all questions posed to him by Defendant Hunter.

7. Defendant Hunter posted Plaintiff's responses to an "Insured's Statement for Disability Benefits".

8. Defendant Hunter requested Plaintiff sign the Statement.

9. Plaintiff did sign said Statement.

10. Plaintiff made premium payments of $87.98 beginning September 7, 2013.

11. Plaintiff continued to make said premium payments on a monthly basis.

12. On November 19, 2013, Plaintiff was injured.

13. Said injury caused the Plaintiff to be disabled.

14. Plaintiff filed for disability benefits with Defendant Mutual of Omaha.

15. Plaintiff was denied benefits by Defendant Mutual of Omaha for the following reasons:

a.) based on obtained medical records, Plaintiff was, "treated from February , 2011 through September 2012 for severe arthritis of Plaintiff's knees".

b.) Plaintiff's actual 2013 income was less than Plaintiff's stated 2013 income of 55,400.00 dollars.

16. The above were the sole reasons that Plaintiff's application for benefits were denied.

17. Defendant Mutual of Omaha refused to make payment of disability payment based solely on this alleged non-disclosure.

18. At all times relevant, Plaintiff supplied true and correct responses, based on his information or belief, to all questions posed to him upon his application for benefits.

Count I
Breach of Contract

19. Plaintiff hereby incorporates all previous averment contained in paragraph 1 through 18 as if set forth in full herein.

20. The parties entered into an agreement wherein Plaintiff agreed to pay premiums and upon receipt of those premiums, Defendants were to provide disability insurance to the Plaintiff should Plaintiff become disabled (a true and correct copy of said agreement is attached herein as Exhibit A).

21. Defendant breached that agreement by failing to provide disability payments as per the agreement (a true and correct copy of a denial letter is attached as Exhibit B).

22. As a direct result of Defendant's breach of this agreement, Plaintiff suffered damages including but not limited to:

a.) expectation damages,

b.) loss of disability benefits,

c.) future loss of disability benefits,

d.) incidental and consequential damages caused by the Defendant's breach.

23. At all times, Plaintiff performed all duties and obligations as per the agreement.

WHEREFORE, Plaintiff requests judgment in excess of arbitration limits.

Count II
Insurance Bad Faith

24.) Plaintiff hereby incorporates all previous averment contained in paragraph 1 through 23 as if set forth in full herein.

25.) Defendant Mutual of Omaha is an insurance company, herein this instance in the business of providing disability insurance.

26.) As such in its dealing with the Plaintiff, who paid premiums, there exists an implied covenant of good faith and fair dealing.

27.) Defendant breached this covenant by refusing to pay disability benefits to Plaintiff.

28.) Defendant lacked a reasonable basis for denial of coverage of benefits.

29.) Defendant knew or recklessly disregarded its lack of reasonable basis for denying Plaintiff's claim.

30.) As a result of the acts of the Defendant, Plaintiff sustained injury and was grievously harmed.

31.) As a result of the actions of Defendant, Plaintiff sustained injuries, which Plaintiff requests damages as follows:

a.) compensatory damages,

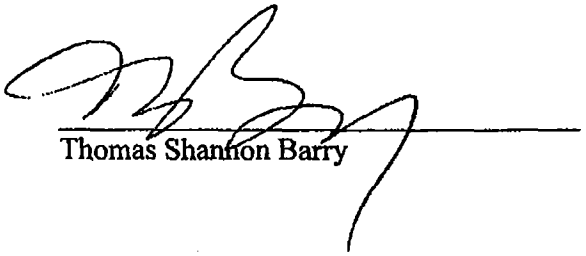
b.) attorney's fees,

c.) court costs,

d.) punitive damages.

WHEREFORE, Plaintiff requests judgment in excess of arbitration limits.

Respectfully submitted,



Thomas Shannon Barry

VERIFICATION

I verify that the statements made in the foregoing COMPLAINT are true and correct. I understand that false statements which are made herein are subject to penalties of 18 Pa.C.S. § 4904, relating to unsworn falsifications to authorities.

BY: _____
David Hines, Plaintiff

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Manager/Commission Code (Required Field for Brokerage)	

314500 N. CHONOFSKY D.V.

DEC/12 9/17 #

MUTUAL OF OMAHA INSURANCE COMPANY
Application for Individual Disability Income Insurance

Mutual of Omaha

SECTION A — GENERAL INFORMATION - COMPLETE FOR ALL CASES

COVERAGE(S) APPLYING FOR

Program	Product (check at least one)
☒ Individual DI	☒ Accident-Only Disability Income ☐ Long-Term Disability (LTD) ☐ Short-Term Disability (STD) ☐ Business Overhead Expense (BOE)

PROPOSED INSURED INFORMATION

Proposed Insured's Name (First, Middle, Last)	Gender	Date of Birth	Birth State
DAVID HINES	☒ Male ☐ Female	10-19-57	PA

Primary Residence Address (Number, Street, City, State, Zip)	Social Security Number
625 MAPLE ST, WEST MIFFLIN, PA 15122	539-68-9186

Mailing Address for Premium Notices (If different than above)	Telephone Number	Best Time to Call
	(412) 612-4671	ANY A.M. P.M.

Full Name of Beneficiary: JOYCE HINES / WIFE — Relationship to Proposed Insured

☒ U.S. Citizen
☐ Permanent Resident (Form I-551) Cardholder residing in the U.S. at least 3 consecutive years (Complete Foreign Travel Questionnaire)

During the last 12 months, have you used any form of tobacco or any form of nicotine replacement therapy (such as nicotine gum, patch or spray)? ☐ Yes ☒ No

EMPLOYMENT INFORMATION

☒ Employee (No Ownership) ☐ Sole Proprietor ☐ Partnership ☐ "S" Corp ☐ "C" Corp % Ownership ____ # of Employees ____

Employer: NEW PENN EXPRESS (City, State): PITTSBURGH, PA

Occupation: DRIVER List exact duties: DELIVERY DRIVER / NO LOADING

1. Are you considered a full-time employee by your employer? ☒ Yes ☐ No # of hours/week: 40-50
2. How long have you been employed by your current employer? 3 YRS
3. Do you have any part-time or off-season occupation? ☐ Yes ☒ No (If "Yes," list exact duties/hours per week)

OTHER COVERAGE AND REPLACEMENT INFORMATION

1. Are you covered under or eligible for: (Check all that apply)
   ☐ (FERS or CSRS) ☐ Railroad Retirement Act ☐ Workers Compensation
2. Are you currently applying for, or do you have in force other disability income coverage, such as: (a) Individual Disability Income; (b) Sick Pay, Association, Retirement/Pension Group Disability Plan; or (c) Business Expense or Buy/Sell Insurance? ☐ Yes ☒ No
   If "Yes," complete the following information:

Company or Source	Pending or Inforce (P/I)	Type (a,b,c)	Benefit Amt. or % of Income	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
		NONE					☐ Yes ☐ No
							☐ Yes ☐ No

3. **Complete only if replacing Mutual of Omaha Insurance Company in-force coverage with another Mutual of Omaha Insurance Company policy.** I am requesting termination of my Policy No. _____ on the effective date of the new policy for which I am applying. I understand that all benefits under the policy being terminated will cease on the effective date of the new policy. **NOTE:** Benefits for which you apply may not take effect whenever there is duplication of benefits which would result in excess coverage.

INCOME INFORMATION

1. Income Information (Attach financial records if required. See underwriting guide for details)	Year-to-Date	Prior Year	2nd Prior Year
(a) Gross Annual Earned Income	$ 55400	70,000	70,000
(b) If self employed, net annual earned income from your occupation (after business expenses and before taxes)	$		
(c) Bonus, First Year Commissions and other incentive payments	$		
(d) Other Earned Income (Part-time, off-season, etc.)	$		
Total	$ 55400	70000	70 000

2. During the preceding tax year, did you receive unearned income (such as dividends, interest, net rentals, pension or renewal commissions) reportable for federal tax purposes or does your tax exempt unearned income exceed $1,500 per month?
   ☐ Yes ☒ No If "Yes," how much per month? _____

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3. In the past 10 years, have you been diagnosed with, received treatment for, tested positive for or been given medical advice by a member of the medical profession for any disease or disorder associated with the following?

- ☐ Anemia or Blood
- ☐ Arthritis or Joints (including replacements)
- ☐ Breast or Male/Female Reproductive organs (such as implants, infertility, irregular menstruation, complication of pregnancy)
- ☐ Cancer or Tumor
- ☐ Chronic Fatigue Syndrome
- ☐ Diabetes or Glandular Condition
- ☐ Fibromyalgia or Myalgia
- ☐ Heart or Coronary Arteries
- ☐ High Blood Pressure, Peripheral Vascular Disease
- ☐ Immune System except those related to Human Immunodeficiency Virus (AIDS Virus)
- ☐ Kidney or Urinary Tract
- ☐ Liver or Hepatitis
- ☐ Lung or Breathing Problem
- ☐ Major Organ Transplant
- ☐ Neurological condition (such as Multiple Sclerosis, Parkinson's, Seizures, Alzheimers, Muscular Dystrophy)
- ☐ Psychological, Emotional or Psychiatric condition
- ☐ Skin or Connective Tissue
- ☐ Spine, Neck or Back
- ☐ Stroke or Cerebral Vascular Condition
- ☐ Upper or Lower Digestive Tract
- ☐ None of These

4. During the last 6 months, have you (a) been prescribed medication(s), or (b) taken any medication(s) prescribed by a physician, or (c) regularly used over-the-counter medication(s)? ..... ☐ Yes ☐ No
If "Yes," please list below. Attach a separate signed sheet if necessary.

Medication Name	Dosage / Frequency	Date Started	Reason	Prescribing Physician & Phone Number (If applicable)

5. During the last 10 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamines and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers or narcotics) other than as prescribed? ..... ☐ Yes ☐ No
(If "Yes," submit a Drug or Alcohol Use Questionnaire)

6. Have you ever been declined, postponed, limited or asked to pay an extra premium for disability benefits by any insurance company? ..... ☐ Yes ☐ No
If "Yes," provide details/date _____.

7. Other than previously answered, during the last 5 years have you received, or been advised by a healthcare provider (including chiropractor) to receive, diagnostic testing or treatment for any chronic medical condition, medical impairment or disability? ..... ☐ Yes ☐ No
If you answered "Yes" to any of the above health questions, provide additional details below. Attach a separate signed sheet if necessary.

Condition, Injury, Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Details of Treatment	Duration of the Condition	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

NOTE: If applying for BOE, proceed to Section E. Otherwise, proceed directly to Section F Plan Information.

SECTION E — COMPLETE ONLY IF APPLYING FOR BUSINESS OVERHEAD EXPENSE INSURANCE

1. Is your business conducted at your place of residence? ..... ☐ Yes ☐ No
If "Yes," what percent of your duties are performed outside of your place of residence? ..... _____ %
2. Date business established? ..... _____
3. What average monthly operating expenses do you incur (or your portion if a joint tenant) for the following? (Use the average monthly operating expenses incurred for the preceding 12 months.)

Employees' Salaries	$ _____	Water	$ _____
Interest on loans	$ _____	Telephone	$ _____
Mortgage interest payments	$ _____	Postage and stationery	$ _____
Insurance (casualty/liability)	$ _____	Equipment rental	$ _____
Property taxes (real and personal)	$ _____	Laundry	$ _____
Depreciation (office equipment only)	$ _____	Other fixed operating expenses (please itemize)	
Rent (including land rental)	$ _____	_____	$ _____
Electricity	$ _____	_____	$ _____
Heat	$ _____	Total Monthly Expenses	$ _____

SECTION B — PLEASE READ AND SIGN

AGREEMENTS AND ACKNOWLEDGEMENTS

1. The undersigned applicant agrees that (a) all answers in this application are true and complete and Mutual of Omaha Insurance Company ("Mutual of Omaha") will rely on these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy issued from its effective date.
2. Applicant acknowledges that Mutual of Omaha may require: medical records, an underwriting assessment, a medical examination, or other information.
3. Applicant agrees that Mutual of Omaha will not issue a policy as a result of this application unless (a) the insurance applicant completes all medical examinations and tests required by Mutual of Omaha, (b) Mutual of Omaha receives any additional information requested for underwriting, and (c) the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance applied for, or the insurance applicant has subsequently accepted an offer by Mutual of Omaha for coverage other than as applied for, according to the underwriting standards of Mutual of Omaha then in force.
4. Applicant agrees that this application does not provide temporary or interim insurance prior to policy issuance. If the applicant has made an advance premium payment, applicant agrees to the terms and conditions under any temporary insurance agreement or conditional receipt. Applicant agrees that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. Applicant acknowledges that if his or her application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to applicant, without interest. No insurance coverage will be in effect until Mutual of Omaha (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.
5. A completed and signed application will become part of each applicant's policy.
6. Applicant acknowledges that no producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.

FRAUD WARNING – Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I have (a) read and understand the Agreements and Acknowledgements and Fraud Warning Sections; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.

Signed at: WEST MIFFLIN (City), PA (State) — Date: 9-7-13

Signature of Proposed Insured: [signature] — Printed Name of Proposed Insured: DAVID HINES — Date: 9-7-13

Signature of Payor as shown on bank account (if Billing Mode is BSP and Payor is other than Proposed Insured) — Printed Name of Payor — Date

Producer Section:

I/We certify that during an interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. ☒ Yes ☐ No

(If "No," please explain.)

I conducted said interview in person ☒ Yes ☐ No

(If "No," please explain.)

[signature]	JOHN HUNTER	9-7-13
Signature of Producer	Producer's Printed Name	Date
CHONESKY DIV	PITTSBURGH, PA 15220	
Office Name	Office Address	
Signature of Producer	Producer's Printed Name	Date
Office Name	Office Address	

MUTUAL OF OMAHA INSURANCE COMPANY
UNITED OF OMAHA LIFE INSURANCE COMPANY

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

"MIB, Inc." means: a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members.

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and any providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental or physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claims information. The personal information may be the entire medical record.

I authorize Medical Persons and Entities that have records or knowledge of me and my children, if they are proposed insureds (My Children) to release personal information about me or My Children to Mutual of Omaha Insurance Company or its affiliated companies (Mutual).

The Personal Information will be used to determine my and My Children's eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual to disclose my and My Children's personal information to MIB, Inc. I understand that my and My Children's personal information received by MIB, Inc. may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I realize if I refuse to sign, the insurance for which I am applying will not be issued.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha NE 68175. This revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

Applicant acknowledges and agrees that if there is more than one proposed insured on this application, all information provided may be reviewed or shared with the other applicant. A completed and signed application will become part of each applicant's policy.

Name(s) used for medical records (if different than the name) below: _____

_____

_____ **Date:** 9-7-13
Signature of Proposed Insured — Mo Day Yr

_____ **Date:** _____
Signature of Spouse (if Proposed Insured) — Mo Day Yr

_____ **Date:** _____
Signature of Parent or Guardian (if Proposed Insured is a Minor) — Mo Day Yr

_____ **Date:** _____
Signature of Non-minor Child (if Proposed Insured is a Non-minor) — Mo Day Yr

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

L8232_0811

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
1 800 268 6443
mutualofomaha.com

March 21, 2014

DAVID HINES
625 MAPLE ST
WEST MIFFLIN PA 15122-1859

Claim Number: 583974738000
Policy Number: 893503-90

Dear Mr. Hines:

We have completed our review of your claim for disability benefits.

Enclosed is a photocopy of your policy application for your review.

Before an insurance policy can be issued, it is necessary that a formal application be completed. The information contained in this application is most important in determining if an applicant is eligible for coverage. If the application is approved, a copy of it is attached to and made a part of the policy. In this way you can check the application for correctness and notify the Company of any errors or omissions.

In the process of developing your claim, we obtained medical records from Gregory Hung MD, Volker Musahl MD, Michael Rogal MD, Jan Pesci MD, and William Annear. These medical records document your were treated from February 2011 through September 2012 for severe arthritis of your knees. This was prior to the issue date of your policy, however, this information was not shown at the time you applied for coverage.

You documented on the application signed September 7, 2013, that you worked for New Penn Express for three years and and that your income was $70,000.00 per year for each of the 2 years prior to applying for coverage (2011 and 2012) and that you had made $55,400.00 as of the application date for 2013.

The income documentation received for 2012 is your 1099G showing you received unemployment in the amount of $28,952.00, a 1099R for a withdrawal of $5650.80 from your retirement savings plan, and 2 W-2 statements showing earned income of $195.11 and $1774.80.

Your pay stub for the period of November 17, 2013 through November 23, 2013 documents a year to date total earnings of $47,125.42. Therefore, you would not have had income of $55,400.00 by September 7, 2013 as stated on your application.

If this information had been shown on your application, your policy would not have been issued in its present form. Now that we have the information, it is necessary for us to take the same

EXHIBIT "A"

RKB	SCHEDULE OF BENEFITS	PREPARED ON 01/12/2015
VERAGE NUMBER D83D2-893503-90M	**EFFECTIVE DATE** 09/07/2013	**PAID TO** 09/07/2013
PREMIUM $87.98	**MODE** MONTHLY	

GROUP NAME (IF APPLICABLE)

DEPENDENTS COVERED

SERIES 21084

PLAN OWNER/MEMBER

DAVID HINES
625 MAPLE ST
WEST MIFFLIN PA 15122

D83D2-893503-90M

NEIL CHONOFSKY DIVISION OFFICE

BASIC COVERAGE/RIDER BENEFITS/POLICY ADJUSTMENTS

TOTAL DISABILITY MONTHLY BENEFIT $3,500.00
ELIMINATION PERIOD: 14 DAYS
BENEFIT PERIOD: 24 MONTHS
DISABILITY INCOME PROTECTION COVERAGE

OML3M SEE ATTACHED RIDER

ALL OF THE ABOVE IS SUBJECT TO THE BENEFITS, CONDITIONS, AND LIMITATIONS OF THE ATTACHED PLAN.
(NOTE: INFORMATION MAY CONTINUE ON REVERSE - PLEASE READ)